AGENDA
ARK-TEX URBAN TRANSIT
BOARD OF DIRECTORS
September 22, 2025

The Ark-Tex Urban Transit, Inc. (ATUT) Board of Directors will meet at 3:00 p.m. on Monday, September 22, 2025, at the Ark-Tex Council of Governments, Conference Room, located at 4808 Elizabeth Street, Texarkana, Texas.

1. Call to order.

2. Public Comment.

3. Review and consider approval of the minutes as submitted for the ATUT Board Meeting held on September 24, 2024. (See page 2**;** to be presented by President Mary Beth Rudel)

4. Review and consider adoption of the ATUT Flexible Benefits Cafeteria Plan for FY2026. (See page 6; to be presented by Human Resource Director Amber Murr)

5. Review and consider approval of the ATUT Ethics Policy Manual. (See page 45; to be presented by Human Resource Director Amber Murr)

6. Review and consider approval of the ATUT Policy Manual Revisions. (See page 73; to be presented at the meeting by Vice President/Treasurer Leslie McBride)

7. Review and consider approval/ratification of TUTD Fiscal Year 2026 Final Budget. (See page 76; to be presented by President Mary Beth Rudel)

Announcement

The next ATUT Board of Directors meeting will be held on an as-needed basis.

Pursuant to the Texas Open Meeting Act, Government Code Chapter 551 one or more of the above items may be considered in an executive session closed to the public, including but not limited to consultation with an attorney pursuant to Texas Government Code Section 551.071 and Section 551.074 arising out of the attorney's ethical duty to advise ATCOG concerning legal issues arising from an agenda item. Any decision held on such a matter will be taken or conducted in an open session following the conclusion of the executive session.

Persons with disabilities who plan to attend this meeting and who may need auxiliary aids or services are requested to contact the Administration at 903-832-8636, two (2) workdays prior to the meeting, so that appropriate arrangements can be made.

All agendas are sent electronically and are available on the ATCOG website at www.atcog.org. Should any Board Member need a copy printed and available at the meeting, please call 903.255.3555 or email mmatthews@atcog.org.

MINUTES
ARK-TEX URBAN TRANSIT
BOARD OF DIRECTORS MEETING
September 24, 2024

A meeting of the Board of Directors of the Ark-Tex Urban Transit, Inc. (ATUT) was held at 3:00 p.m. on Thursday, September 24, 2024, at Ark-Tex Council of Governments, 4808 Elizabeth Street, Texarkana, Texas.

Item 1. Mary Beth Rudel, Board President, called the meeting to order.

Item 2. Public comment.

No members of the public were present.

Regular Business

Item 3. The next order of business was to approve the minutes submitted for the ATUT Board Meeting held on January 18, 2024.

Motion to approve was made by Leslie McBride, Vice-President/Treasurer, and seconded by Mary Beth Rudel, President. It was approved.

Item 4. Ms. Amber Murr presented for consideration approval of the adoption of the ATUT Flexible Benefits Cafeteria Plan for FY 2025.

The ATUT Flexible Benefits Cafeteria Plan will allow ATUT to offer additional benefits to employees on a pre-tax basis, such as cancer, critical illness, and accident insurance. ATUT remains in compliance with Section 125 of the Internal Revenue Code of 1986 by updating the written plan annually and distributing it to all eligible employees, offering the plan to all eligible employees, and completing nondiscrimination testing on the plan to ensure only those who are eligible are receiving the pre-tax benefit.

Motion to approve was made by Leslie McBride and seconded by Mary Beth Rudel. It was approved.

Item 5. Ms. Amber Murr presented for review and consideration approval of the ATUT Ethics Policy Manual.

On January 29, 2009, the Texas Transportation Commission adopted administrative rules that require outside entities to implement internal ethics and compliance programs. To remain eligible to receive the funding, ATUT is required to renew the manual annually. In addition, another rule adopted on March 25, 2010, requires public transportation entities to implement and enforce a compliance program meeting the minimum rules in order to be eligible for state and federal funding awarded after January 1, 2011, by the Texas Transportation Commission.

ATUT enforces a compliance program by reviewing and providing all employees a copy of the “Ethics Policy Manual” during new hire orientation and conducting yearly Ethics Manual Training that is mandatory for all employees. No changes have been made to the Ethics Policy manual.

Motion to approve was made by Leslie McBride and seconded by Mary Beth Rudel. It was approved.

Item 6. Ms. Leslie McBride presented for review and consideration approval of the ATUT Policy Manual Revisions. The policy revisions were provided at the meeting. The policy changes highlighted are as follows:

1.10 Job Posting and Employee Referrals

Paragraph 2

- All job postings for 10 days
- Applicants may utilize computers located at T Line

3.02 Holidays

Paragraph 2

- Holidays shall be paid for full-time employees who would have been regularly scheduled to work that day for the number of hours they would have regularly been scheduled to work.

3.03 Floating Holidays (Personal Days)

Paragraph 1

- Deleted (8-hour days) and (8-hour increments)

5.02 Inclement Weather

Paragraph 1

- Renaming the Manager of Public Transportation to *Transportation Director,* and Operations Supervisor to *Transportation Manager,* and Operations Supervisors to Operations *Coordinator*

5.08 Business Travel Expenses

Paragraph 1

- Renaming Finance Manager to Finance *Director*

6.01 Vacation Leave

Paragraph 3

- Deleting 10 days and replacing with 80.00 hours
  Employees may accrue a maximum total of 80.00 hours without loss of benefits.

Paragraph 4

- Deleting 11 vacation days and replacing with 88.00 hours of vacation leave
  Employees may accrue a maximum total of 88 hours without loss of benefits.

Paragraph 5

- Deleting one day and replacing with 8 hours
  Deleting 20 days and replacing with 160 hours of vacation time
  Deleting 20 days and replacing with 160 hours per year of length of service

Paragraph 6

- Added: Full-time employees will be allowed to carry over vacation leave into the next fiscal year up to the maximum accrual according to years of service. (Deleted 160 hours)

6.02 Sick Leave

Paragraph 2

- Deleted or a half day

- Added: At the time an employee's sick leave balance reaches a maximum accrual (480 hours), the employee will not accrue any further sick leave nor will the employee be compensated for any excess.

7.04 Personal Appearance
Paragraph 4
- Added "jeans"

Paragraph 5
- Added: Examples of inappropriate dress, but not limited to:

1. An employee who is required to wear a uniform that is found to be out-of-uniform.
2. Sheer, tight, ill-fitting clothing
3. Sleeveless tops, tank tops, spaghetti straps, and cold shoulder tops (under shirts should not be worn as
4. shirts even with jackets or open sweaters worn over)
5. Crop tops
6. Flip flops or sandals that are too casual (Example: Plastic sandals or Crocs)
7. No heels higher than 3 inches (office employees)
8. Operators may not wear open-toed shoes
9. Revealing or low-cut tops (exposure on the back cannot be greater than the allowable exposure if the top were turned around)
10. Hats, caps, or head coverings, except for religious or medical reasons or outside work that dictates head coverings
11. No extreme visible piercings (Examples: facial piercings, stretching or gauging in ears)
12. No extreme hair colors
13. Tattoos that are not easily covered

7.05 Casual Days - Deleted Policy; Addressed in Personal Appearance 7.04

Motion to approve was made by Leslie McBride and seconded by Mary Beth Rudel. It was approved.

Item 7. Review and consider approval of designation of new Trustee and new Primary Contact for the Ark-Tex Urban Transit, Inc. Retirement Plan.

The recent position changes at the Ark-Tex Council of Governments have created the need to designate a new Trustee and Primary Contact for the ATUT Retirement Plan. Currently, Mary Beth Rudel, Executive Director, is designated as a Trustee, and Leslie McBride, Deputy Director, is designated as a Trustee and the Primary Contact for the Plan. Ms. Rudel and Ms. McBride will remain as Trustees. ATCOG requests that Amber Murr, Human Resources Director, be designated as a new Trustee and the Primary Contact for the ATUT Retirement Plan.

Motion to approve was made by Leslie McBride and seconded by Mary Beth Rudel. It was approved.

Item 8. Ms. Mary Beth Rudel presented for review and consideration approval/ratification of TUTD Fiscal Year 2025 Final Budget.

Ms. Melinda Tickle noted that the agenda stated Fiscal Year 2024. Ms. Rudel requested that the minutes reflect the correction to the ATUT agenda to state TUTD Fiscal Year 2025 Final Budget.

Ms. Rudel reviewed the budget with the ATUT Board. She stated that ATUT would only need to approve the salary portion of the budget. She requested approval of ATUT Total Salaries in the amount of 1,129,173.00, as presented in the budget.

Motion to approve was made by Leslie McBride and seconded by Mary Beth Rudel. It was approved.

Announcement

The next ATUT Board of Directors meeting will be held on an as-needed basis.

_____
Mary Beth Rudel, President
Board of Directors
Ark-Tex Urban Transit, Inc.

_____
Leslie McBride, Vice-President/Treasurer
Board of Directors
Ark-Tex Urban Transit, Inc.

BRIEFING PAPER

ITEM 4:

Review and consider the adoption of the ATUT Flexible Benefits Cafeteria Plan for fiscal year 2026.

BACKGROUND:

Section 125 of the Internal Revenue Code of 1986 allows employers to adopt cafeteria plans to offer employees certain benefits on a pre-tax basis. ATUT has chosen to adopt the ATUT Flexible Benefits Cafeteria Plan to continue to offer certain benefits on a pre-tax basis to eligible employees.

DISCUSSION:

Upon adoption, the ATUT Flexible Benefits Cafeteria Plan will allow ATUT to offer additional benefits to employees on a pre-tax basis, such as cancer, critical illness, and accident insurance. ATUT remains in compliance with Section 125 of the Internal Revenue Code of 1986 by updating the written plan annually and distributing it to all eligible employees, offering the plan to all eligible employees, and completing nondiscrimination testing on the plan to ensure only those who are eligible are receiving the pre-tax benefit.

RECOMMENDATION:

Staff recommends approval.

THE ARK TEX COUNCIL OF GOVERNM
FBP CAFETERIA PLAN

ARTICLE I. Introductory Provisions

ARK TEX COUNCIL OF GOVERNM FBP ("the Employer") hereby amends and restates the ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan ("the Plan") effective as of 10/1/2013 5:00:00 AM. The Plan was originally effective 10/1/2010 5:00:00 AM. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to allow an Eligible Employee to pay for his or her share of Contributions under one or more Insurance Plans on a pre-tax Salary Reduction basis.

This Plan is intended to qualify as a "cafeteria plan" under Code § 125 and the regulations issued thereunder. The terms of this document shall be interpreted to accomplish that objective.

Although reprinted within this document, the different components of this Plan shall be deemed separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed on such components by the Code.

ARTICLE II. Definitions

"Accident Insurance Benefits (Also includes Accidental Death & Dismemberment (AD&D))" means the Employee's Accident/Accidental Death & Dismemberment Insurance Plan coverage for purposes of this Plan.

"Accident Plan(s) (Also includes Accidental Death & Dismemberment (AD&D)Plans)" means the plan(s) that the Employer maintains for its Employees providing benefits through a group insurance policy or policies in the event of injury or accidental death and/or dismemberment. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"Benefits" means the Premium Payment Benefits.

"Benefit Package Option" means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

"Change in Status" has the meaning described in Section 4.6.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Contributions" means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits.

"Committee" means the Benefits Committee (or the equivalent thereof) of ARK TEX COUNCIL OF GOVERNM FBP

"Compensation" means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

"Dental Insurance Benefits" means the Employee's Dental Insurance Plan coverage for purposes of this Plan.

"Dental Insurance Plan(s)" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan(s)) providing dental benefits through a group insurance policy or policies. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code § 152, with the following exceptions: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component, and for purposes of the Health FSA Component), (1) a dependent is defined as in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) any child to whom IRS Rev. Proc. 2008-48 applies. Furthermore, notwithstanding anything in the foregoing that may be to the contrary, a "Dependent" shall also include for purposes of any accident or health coverage provided under this plan a child of a Participant who has not attained age 27 by the end of any given taxable year.

"Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as

disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity or pursuant to workers' compensation.

"Effective Date" of this Plan has the meaning described in Article 1.

"Election Form/Salary Reduction Agreement" means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for Premium Payment Benefits. This form may be in either paper or electronic form at the Employer's discretion in accordance with the procedures detailed in Article IV.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in Section 3.1.

"Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"Employer" means ARK TEX COUNCIL OF GOVERNM FBP, and any Related Employer that adopts this Plan with the approval of ARK TEX COUNCIL OF GOVERNM FBP. Related Employers that have adopted this Plan, if any, are listed in Appendix A of this Plan. However, for purposes of Articles XI and XIV and Section 15.3, "Employer" means only ARK TEX COUNCIL OF GOVERNM FBP.

"Employment Commencement Date" means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Health Insurance Benefits" means any insurance benefits providing medical or other health insurance coverage through a group insurance policy or policies.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HMO" means the health maintenance organization Benefit Package Option under the Medical Insurance Plan.

"Hospital Indemnity Benefits" means the Employee's Hospital Indemnity Plan coverage for purposes of this Plan.

"Hospital Indemnity Plan(s)" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan(s)) providing certain indemnity benefits in the event of hospitalization or other similar medical event through a group insurance policy or policies. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45.

"Insurance Benefits" means benefits offered through the Insurance Plans.

"Insurance Plan(s)" means a plan or plans offering benefits through a group insurance policy or policies.

"Medical Insurance Benefits" means the Employee's Medical Insurance Plan coverage for purposes of this Plan.

"Medical Insurance Plan(s)" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies (with HMO and PPO options). The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"Open Enrollment Period" with respect to a Plan Year means any period before the beginning of the Plan Year that may be prescribed by the Administrator as the period of time in which Employees who will be Eligible Employees at the beginning of the Plan Year may elect benefits.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Medical Insurance Benefits and (b) those who elect instead to receive their full salary in cash and to pay for their share of their Contributions under the Medical Insurance Plan.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

"Plan" means the ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan as set forth herein and as amended from time to time.

"Plan Administrator" means the ARK TEX COUNCIL OF GOVERNM FBP Human Resources Manager or the equivalent thereof for ARK TEX COUNCIL OF GOVERNM FBP, who has the full authority to act on behalf of the Plan Administrator, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Plan Administrator, as described in Section 13.1.

"Plan Year" means the 12-month period commencing 10/1/2025 and ending on 9/30/2026, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

"PPO" means the preferred provider organization Benefit Package Option under the Medical Insurance Plan.

"Premium Payment Benefits" means the Premium Payment Benefits that are paid for on a pre-tax Salary Reduction basis as described in Section 6.1.

"Premium Payment Component" means the Component of this Plan described in Article VI.

"QMCSO" means a qualified medical child support order, as defined in ERISA § 609(a).

"Related Employer" means any employer affiliated with ARK TEX COUNCIL OF GOVERNM FBP that, under Code § 414(b), § 414(c), or § 414(m), is treated as a single employer with ARK TEX COUNCIL OF GOVERNM FBP for purposes of Code § 125(g)(4).

"Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable Component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

"Specified Disease or Illness Insurance Benefits" means the Employee's Specified Disease or Illness Insurance Plan coverage for purposes of this Plan.

"Specified Disease or Illness Insurance Plan(s)" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan(s)) providing certain benefits with regard to a particular critical illness or illnesses (e.g., a "cancer policy" or the like) through a group insurance policy or policies. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

"Vision Insurance Benefits" means the Employee's Vision Insurance Plan coverage for purposes of this Plan.

"Vision Insurance Plan(s)" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan(s)) providing vision benefits through a group insurance policy or policies. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual: (a) is an Employee; (b) is working 30 hours or more per week; and (c) has been employed by the Employer for a consecutive period of 0 days, counting his or her Employment Commencement Date as the first such day. Eligibility for Premium Payment Benefits may also be subject to the additional requirements, if any, specified in the Medical Insurance Plan. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective the first day of the next calendar month, in accordance with the procedures described in Article IV.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

- the termination of this Plan; or
- the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6.4 for Insurance Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Medical Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Medical Insurance Plan (here, major medical insurance) is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 3.1 before again becoming eligible to participate in the Plan.

3.4 FMLA Leaves of Absence

(a) Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health Insurance Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require participants to continue all Health Insurance Benefits coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (for instance, on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Health Insurance Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Health Insurance Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Health Insurance Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Medical Insurance Benefits upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In

addition, the Plan may require Participants whose Health Insurance Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage.

(b) Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules detailed in Article IV will apply.

ARTICLE IV. Method and Timing of Elections; Irrevocability of Elections

4.1 Elections When First Eligible

Unless an Employee who becomes an Eligible Employee mid-Plan Year informs the Employer in writing (or in an electronic form accepted by Employer) that he or she does not want to be enrolled in any benefits under the Plan, such Employee will be automatically enrolled in the benefits on the first day of the month after the eligibility requirements have been satisfied.

Benefits shall be subject to the additional requirements, if any, specified in the Medical Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in any Insurance Plans.

4.2 Elections During Open Enrollment Periods

During each Open Enrollment Period with respect to a Plan Year, the Plan Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the Benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Plan Administrator on or before the last day of the Open Enrollment Period, and it shall become effective on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Open Enrollment Period, then the Employee may not elect any Benefits under this Plan until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described in Article IV.

The Employer reserves the right, within its discretion, to allow or require any or all of the election procedures detailed in this Article 4.2 to be performed electronically.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Section 4.2, then the Employee may not elect any Benefits under the Plan (a) until the next Open Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described in Article IV. If an Employee who fails to file an Election Form/Salary Reduction Agreement is eligible for Medical Insurance Benefits and has made an effective election for such Benefits, then the Employee's share of the Contributions for such Benefits will be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period (or after an event occurs that would justify a mid-year election change as described in Article IV), a timely Election Form/Salary Reduction Agreement to elect Premium Payment Benefits. Until the Employee files such an election, the Employer's portion of the Contribution will also be paid outside of this Plan.

4.4 Irrevocability of Elections

Unless an exception applies (as described in this Article IV), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

Unless otherwise noted in this section, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- Participation in this Plan;
- Salary Reduction amounts; or
- election of particular Benefit Package Options.

4.5 Procedure for Making New Election If Exception to Irrevocability Applies

(a) Timeframe for Making New Election. A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.6 or 4.7, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.7(d) through 4.7(j), within 30 days after the events described in such Sections unless otherwise required by law). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing dependent status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) Effective Date of New Election. Elections made pursuant to this Section 4.5 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.7(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

4.6 Change in Status Defined

Participant may make a new election upon the occurrence of certain events as described in Section 4.7, including a Change in Status, for the applicable Component. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) Legal Marital Status. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) Number of Dependents. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) Employment Status. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) Dependent Eligibility Requirements. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, or any similar circumstance; and

(e) Change in Residence. A change in the place of residence of the Participant or his or her Spouse or Dependents.

4.7 Events Permitting Exception to Irrevocability Rule

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Component of this Plan:

(a) Open Enrollment Period. A Participant may change an election during the Open Enrollment Period.

(b) Termination of Employment. A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.2 and 3.3, as applicable.

(c) Leaves of Absence. A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

(d) Change in Status. A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.6), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

(1) Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

(2) Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(e) HIPAA Special Enrollment Rights. If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

- a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

- a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of this Section 4.7(e), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Certain Judgments, Decrees and Orders. If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) Medicare and Medicaid. If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.

(h) Change in Cost. For purposes of this Section 4.7(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage.

(1) Increase or Decrease for Insignificant Cost Changes. Participants are required to increase their elective contributions (by

increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution.The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) Significant Cost Increases. If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage; or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) Significant Cost Decreases. If the Plan Administrator determines that the cost of any Benefit Package Option significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost Medical Insurance Plan); or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(i) Change in Coverage. The definition of "similar coverage" under Section 12.4(h) applies also to this Section 12.4(i).

(1) Significant Curtailment. If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) Significant Curtailment Without Loss of Coverage. If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage. Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) Significant Curtailment With a Loss of Coverage. If the Plan Administrator determines that a Participant's Benefit Package Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) Definition of Loss of Coverage. For purposes of this Section 4.7(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

(2) Addition or Significant Improvement of a Benefit Package Option. If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or

significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance. A Participant entitled to change an election as described in this Section 4.7 must do so in accordance with the procedures described in Section 4.5.

(j) Revocation Due to Reduction in Hours

A Participant may revoke his or her Major Medical coverage, along with that of any related individuals, if the Participant experiences a reduction of hours such that he or she will be reasonably expected to work fewer than 30 hours a week on a regular basis and the Participant intends to enroll, along with any such related individuals, in another plan no later than the first day of the second full month following the revocation.

(k) Exchange Enrollment

A Participant who is eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period may prospectively revoke his or her election for Medical Insurance Plan coverage, provided that the Participant certifies that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of the Medical Insurance Plan coverage. If one or more of a Participant’s related individuals are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during an Exchange special or annual open enrollment period, the Participant may prospectively revoke an election for Medical Insurance Plan coverage for the individual or individuals (and switch to self-only coverage or family coverage including one or more other related individuals), provided that the Participant certifies that the individuals whose coverage is being revoked have enrolled or intend to enroll in new Exchange coverage that is effective no later than the day immediately following the last day of their Medical Insurance Plan coverage.

(l) CHIP Special Enrollment Rights

Notwithstanding anything else in this document to the contrary, special enrollment rights shall be made available as a result of a loss of eligibility for Medicaid or for coverage under a state children's health insurance program (SCHIP) or as a result of eligibility for a state premium assistance subsidy under the plan from Medicaid or SCHIP.

4.8 ***Reserved***

4.9 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect Premium Payment Benefits, as described in Article VI.

5.2 Employer and Participant Contributions

(a) Employer Contributions. For Participants who elect Insurance Benefits described in Article VI, the Employer may contribute a portion of the Contributions as provided in the open enrollment materials furnished to Employees and/or on the Election Form/Salary Reduction Agreement.

(b) Participant Contributions. Participants who elect any of the Medical Insurance Benefits described in Article VI may pay for the cost of that coverage on a pre-tax Salary Reduction basis, or with after-tax deductions, by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

(a) Salary Reductions per Pay Period. The Salary Reduction for a pay period for a Participant is, for the Benefits elected, (1) an amount equal to the annual Contributions for such Benefits (as described in Section 6.2 for Premium Payment Benefits; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate).

(b) Considered Employer Contributions for Certain Purposes. Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits are considered to be Employer contributions.

(c) Salary Reduction Balance Upon Termination of Coverage. If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

(d) After-Tax Contributions for Premium Payment Benefits. For those Participants who elect to pay their share of the Contributions for any of the Medical Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected as Employer and Participant Contributions for Premium Payment Benefits, as described in Section 6.2.

ARTICLE VI. Premium Payment Component

6.1 Benefits

The only Insurance Benefits that are offered under the Premium Payment Component are benefits under the Medical, Dental, Vision, Accident, Accidental Death & Dismemberment, Bridge, Hospital Indemnity, Specific Disease or Condition Insurance Plan(s). Notwithstanding any other provision in these Plan(s), these benefits are subject to the terms and conditions of the Insurance Plan(s), and no changes can be made with respect to such Insurance Benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for Medical Insurance Benefits on a pretax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Component and to pay for his or her share of the Contributions, if any, for Medical Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Article IV), such election is irrevocable for the duration of the Period of Coverage to which it relates.

The Employer may at its discretion offer cash in lieu of benefits for Participants who do not choose Insurance Benefits.

6.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which

may or may not be the same amount charged by the insurance carrier.

6.3 Insurance Benefits Provided Under Insurance Plans

Insurance Benefits will be provided by the Insurance Plans, not this Plan. The types and amounts of Insurance Benefits, the requirements for participating in the Insurance Plans, and the other terms and conditions of coverage and benefits of the Insurance Plans are set forth in the Insurance Plans. All claims to receive benefits under the Insurance Plans shall be subject to and governed by the terms and conditions of the Insurance Plans and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Health Insurance Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents,as applicable, whose coverage terminates under the Health Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health Insurance Plan(s) the day before the qualifying event for the periods prescribed by COBRA.

Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for Health Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

ARTICLES VII. - XII. ***RESERVED***

ARTICLE XIII. Appeals Procedure

13.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with the claims procedure set forth in the summary plan description for this Plan. The Committee acts on behalf of the Plan Administrator with respect to appeals.

13.2 Claims Procedures for Insurance Benefits

Claims and reimbursement for Insurance Benefits shall be administered in accordance with the claims procedures for the Insurance Benefits, as set forth in the plan documents and/or summary plan description(s) for the Insurance Plan(s).

ARTICLE XIV. Recordkeeping and Administration

14.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

14.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan

Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

14.4 ***Reserved***

14.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

14.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

14.7 Bonding

The Plan Administrator shall be bonded to the extent required by ERISA.

14.8 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts at its discretion. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

14.9 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

14.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the

extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XV. General Provisions

15.1 ***Reserved***

15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

15.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of TX, to the extent not superseded by the Code, ERISA, or any other federal law.

15.5 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code , ERISA (if ERISA is applicable) and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA (if ERISA is applicable), the provisions of the Code and ERISA (if ERISA is applicable) shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

15.6 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

15.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

15.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

15.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

15.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

15.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the ARK TEX COUNCIL OF GOVERNM FBP Salary Reduction Plan, ARK TEX COUNCIL OF GOVERNM FBP has caused this Plan to be executed in its name and on its behalf, on this ____ day of _____, 20___.

ARK TEX COUNCIL OF GOVERNM FBP

By: _____
Its: _____

Amendment to the ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan with Regard to Health Savings Accounts
Effective , the ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan is amended as follows:

ARTICLE II is amended by adding the following:

"Benefits" can mean, according to the context used, either Premium Payment Benefits or HSA Benefits (in the form of Contributions to an HSA).

"Contributions" can mean, according to the context used, either 1) the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits or 2) contributions to a health savings account.

"Health Savings Account (HSA)" has the meaning provided in § 223 of the Code.

"High-Deductible Health Plan (HDHP)" has the meaning given in § 223 of the Code.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Medical Insurance Benefits and/or elect to make HSA Contributions under this Plan, or (b) those who elect instead to receive their full salary in cash and to pay for their share of their Contributions under the Medical Insurance Plan.

ARTICLE IX is not "Reserved" but instead reads as follows:

ARTICLE IX. HSA Component

9.1 HSA Benefits

An Eligible Employee can elect to participate in the HSA Component by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's HSA established and maintained outside the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited (this funding feature constitutes the HSA Benefits offered under this Plan). Any language in the document to the contrary notwithstanding, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

9.2 Contributions for Cost of Coverage for HSA; Maximum Limits

The annual Contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant. In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the Contribution is made.

An additional catch-up Contribution may be made for Participants who are age 55 or older.

In addition, the maximum annual Contribution shall be:

(a) reduced by any matching (or other) Employer Contribution, if any, made on the Participant's behalf made under the Plan; and

(b) prorated for the number of months in which the Participant is an HSA-Eligible Individual.

9.3 ***Reserved***

9.4 Recording Contributions for HSA

As described in Section 9.6, the HSA is not an employer-sponsored employee benefit plan - it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The HSA trustee/custodian will be chosen by the Participant, not by the Employer. The Employer may, however, limit the number of HSA providers to whom it will forward contributions that the Employee makes via pre-tax Salary Reductions - such a list is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

9.5 Tax Treatment of HSA Contributions and Distributions

The tax treatment of the HSA (including contributions and distributions) is governed by Code § 223.

9.6 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan

HSA Benefits under this Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). The Employer has no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising an amendment to the ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan, ARK TEX COUNCIL OF GOVERNM FBP has caused this amendment to be executed in its name and on its behalf, on this 12th day of August 2025.

ARK TEX COUNCIL OF GOVERNM FBP

By: _____

Its: _____

THE ARK TEX COUNCIL OF GOVERNM
FBP CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

Introduction

ARK TEX COUNCIL OF GOVERNM FBP sponsors the ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan (the "Cafeteria Plan") that allows eligible Employees to choose from a menu of different benefits paid for with pre-tax dollars. (Such plans are also commonly known as "salary reduction plans" or "Section 125 plans").

This Summary Plan Description ("SPD") describes the basic features of the Cafeteria Plan, how it generally operates and how Employees can gain the maximum advantage from it.

PLEASE NOTE: This SPD is for general informational purposes only. It does not describe every detail of the Cafeteria Plan. If there is a conflict between the Cafeteria Plan documents and this SPD, then the Cafeteria Plan documents will control.

Cafeteria Plan

CAF Q-1. How do I pay for ARK TEX COUNCIL OF GOVERNM FBP benefits on a pre-tax basis?

If you become eligible for the plan during the plan year, your Employer will automatically enroll you in the plan unless you indicate to your Employer in writing (or electronically) that you do not wish to be so enrolled.

For subsequent plan years, you may elect to pay for benefits on a pre-tax basis by entering an election with the Employer during the Open Enrollment Period. At the Employer's option, this may be done with a traditional "paper" salary reduction agreement or it may be done in electronic form. Whatever medium is used, it shall be referred to as a Salary Reduction Agreement for purposes of this SPD.

When you pay for benefits on a pre-tax basis, you reduce your salary to pay for your share of the cost of coverage with pretax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes.");

Example CAF Q-1(a): Sally is paid an annual salary of $30,000. Sally elects to pay for $2,000 worth of benefits for the Plan Year on a pre-tax basis. By doing so, she is electing to reduce her salary, and therefore also her taxable income, by $2,000 for the year to $28,000.

From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Example CAF Q-1(b): Using the same facts from Example Q-1(a), suppose Sally is paid 26 times a year (bi-weekly). Because she has elected $2,000 in benefits, she will have $76.92 deducted from each paycheck for the year ($2,000 divided by 26 paychecks equals $76.92).

CAF Q-2. What benefits may be elected under the Cafeteria Plan?

The Cafeteria Plan includes the following benefit plans:

The Premium Payment Component permits an Employee to pay for his or her share of contributions for insurance plans with pretax dollars. Under the ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan, these benefits may include:

* Accident
* Accidental Death & Dismemberment
* Bridge
* Dental
* HSA
* Hospital Indemnity
* Specific Disease or Condition
* Medical
* Vision

If you select any or all of these benefits, you will likely pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you as necessary from time to time.

The Employer may at its own discretion offer cash in lieu of benefits for participants who do not choose benefits. If the Employer does choose this option, participants will be informed through other communications.

CAF Q-3. Who can participate in the Cafeteria Plan?

Employees who are working 30 hours per week or more are eligible to participate in the Cafeteria Plan following 0 days of employment with the Employer, provided that the election procedures in CAF Q-5 are followed.

An "Employee" is any individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll.

Please note: "Employee" does not include the following:

(a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer;

(b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer;

(c) ***RESERVED***;

(d) any individual considered "self-employed" by the IRS because of an ownership interest in ARK TEX COUNCIL OF GOVERNM FBP;

CAF Q-4. What tax savings are possible under the Cafeteria Plan?

You may save both federal income tax and FICA (Social Security/Medicare) taxes by participating in the ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan.

Example CAF Q4(a): Suppose Sally pays 15% in federal income taxes for the year. With an annual salary of $30,000, that could mean as much as $4,500 in federal income taxes, plus $2,295 in FICA taxes (calculated at 7.65% of income). But by electing $2,000 of cafeteria plan benefits for the year, Sally lowers her income by $2,000, meaning she is only taxed on $28,000. This comes out to $4,200 in income tax plus $2,142 in FICA tax. That's a $453 tax savings for the year.

(**Caution**: This example is intended to illustrate the general effect of "pre-taxing" benefits through a cafeteria plan. It does not take into account the effects of filing status, tax exemptions, tax deductions and other factors affecting tax liability. Furthermore, the amount of the contributions used in this example is not meant to reflect your actual contributions. It is also not intended to reflect specifically upon your particular tax situation. You are encouraged to consult with your accountant or other professional tax advisor with regard to your particular tax situation, especially with regard to state and local taxes.)

CAF Q-5. When does participation begin and end in the Cafeteria Plan?

After you satisfy the eligibility requirements, you can become a Participant on the first day of the next calendar month by electing benefits in a manner such as described in CAF Q-1. An eligible Employee who does not elect benefits will not be able to elect any benefits under the Cafeteria Plan until the next Open Enrollment Period (unless a "Change in Election Event" occurs, as explained in CAF Q-7).

An Employee continues to participate in the Cafeteria Plan until (a) termination of the Cafeteria Plan; or (b) the date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason). However, for purposes of pre-taxing COBRA coverage for Health Insurance Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See CAF Q-8 and CAF Q-12 for more information about this as information about how termination of participation affects your Benefits.

CAF Q-6. What is meant by "Open Enrollment Period" and "Plan Year"?

The "Open Enrollment Period" is the period during which you have an opportunity to participate under the Cafeteria Plan by electing to do so. (See Q-5.) You will be notified of the timing and duration of the Open Enrollment Period, which for any new Plan Year generally will occur during the quarter preceding the new Plan Year.

The Plan Year for the ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan is the period beginning on 10/1/2025 and ending on 9/30/2026.

CAF Q-7. Can I change my elections under the Cafeteria Plan during the Plan Year?

Except in the case of HSA elections, you generally cannot change your election to participate in the Cafeteria Plan or vary the salary reduction amounts that you have selected during the Plan Year (this is known as the "irrevocability rule"). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year.

However, there are several important exceptions to the irrevocability rule, many of which have to do with events in your personal or professional life that may occur during the Plan Year.

Here are the exceptions to the irrevocability rule:

1. Leaves of Absence

You may change an election under the Cafeteria Plan upon FMLA and non-FMLA leave only as described in CAF Q-14.

2. Change in Status.

If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment);
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Cafeteria Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as an employee's child covered as a dependent by an accident or health plan who turns 27 during the taxable year); or
- a change in your, your Spouse's, or your Dependent's place of residence.

3. Change in Status - Other Requirements.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility.

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For Health Insurance Benefits, a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

  However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Cafeteria Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See CAF Q-12.

- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another Employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Cafeteria Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other Employer's plan.

4. Special Enrollment Rights. In certain circumstances, enrollment for Health Insurance Benefits may occur outside the

Open Enrollment Period, as explained in materials provided to you separately describing the Health Insurance Benefits. When a special enrollment right explained in those separate documents applies to your Medical Insurance Benefits, you may change your election under the Cafeteria Plan to correspond with the special enrollment right. Special enrollments may also be available as a result of a loss of eligibility for Medicaid or for coverage under a state children's health insurance program (SCHIP) or as a result of eligibility for a state premium assistance subsidy under the plan from Medicaid or SCHIP.

5. Certain Judgments, Decrees, and Orders. If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Health Insurance Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Insurance Plan. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage.

7. Change in Cost. If the cost charged to you for your Health Insurance Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefit package option provides similar coverage. Coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.) If the cost of Health Insurance significantly decreases during the Plan Year, then the Plan Administrator may permit the following election changes: (a) if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions; (b) if you are enrolled in another benefit package option (such as the HMO option under the Medical Insurance Plan), you may change your election on a prospective basis to elect the benefit package option that has decreased in cost (such as the PPO option under the Medical Insurance Plan); or (c) if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost.

The Plan Administrator generally will notify you of increases or decreases in the cost of Health Insurance benefits.

8. Change in Coverage. You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your Health Insurance Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally loss of one particular physician in a network does not constitute significant curtailment.) If your Health Insurance Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage.
- *Addition or Significant Improvement of Cafeteria Plan Option.* If the Cafeteria Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.
- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your

Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does.

For example, if an election to drop coverage is made by your Spouse during his or her Employer's open enrollment, you may add coverage under the Cafeteria Plan to replace the dropped coverage.

9. Exchange Enrollment

If you are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke your election for Medical Insurance Plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of the Medical Insurance Plan coverage. If one or more of your related individuals are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke an election for Medical Insurance Plan coverage for the individual or individuals (and switch to self-only coverage or family coverage including one or more other related individuals), provided that you certify that the individuals whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of the Medical Insurance Plan coverage.

CAF Q-8. What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, then your active participation in the Cafeteria Plan will cease and you will not be able to make any more contributions to the Cafeteria Plan for Insurance Benefits.

See CAF Q-12 for information on your right to continued or converted group health coverage after termination of your employment.

For purposes of pre-taxing COBRA coverage for Health Insurance Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See CAF Q-12.

If you are rehired within the same Plan Year and are eligible for the Cafeteria Plan, then you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, then your prior elections will be reinstated.

If you cease to be an eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described in CAF Q-3 before again becoming eligible to participate in the Plan.

CAF Q-9. ***RESERVED***

CAF Q-10. How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to amend or terminate all or any part of the Cafeteria Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Cafeteria Plan be amended accordingly.

CAF Q-11. What happens if my claim for benefits is denied?

Insurance Benefits

The applicable insurance company will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). For more information about how to file a claim and for details regarding the medical insurance company's claims procedures, consult the claims procedure applicable under that plan or policy, as described in the plan document or summary plan description for the Insurance Plan.

Appeals.

If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the "Committee" (the Benefits Committee that acts on behalf of the Plan Administrator with respect to appeals). Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review.

Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will beprovided free of charge to you upon request;

CAF Q-12. What is "Continuation Coverage" and how does it work?

COBRA

If you have elected Health Insurance Benefits under this Plan, you may have certain rights to the continuation of such benefits after a "Qualifying Event" (e.g., a termination of employment). See Appendix B of this SPD for a detailed description of your rights to "continuation coverage" under COBRA.

USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

CAF Q-13. How will participating in the Cafeteria Plan affect my Social Security and other benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable income, which may result in a decrease in your Social Security benefits and/or other benefits which are based on taxable income. However, the tax savings that you realize through Cafeteria Plan participation will often more than offset any reduction in other benefits. If you are still unsure, you are encouraged to consult with your accountant or other tax advisor.

CAF Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence.

If the Employer is subject to the federal Family and Medical Leave Act of 1993 and you go on a qualifying leave under the FMLA, then to the extent required by the FMLA your Employer will continue to maintain your Health Insurance Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Medical Insurance Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Insurance Benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pretax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Insurance Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to.

If your Health Insurance coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave.

If you are commencing or returning from FMLA leave, then your election for non-health benefits provided under this Plan, if any, will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence.

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply.

Premium Payment Benefits

PREM Q-1. What are "Premium Payment Benefits"?

As described in CAF Q-1, if you elect Premium Payment Benefits you will be able to pay for your share of contributions for Insurance Benefits with pre-tax dollars by electing to do so. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See Q-4.

PREM Q-2. How are my Premium Payment Benefits paid?

As described in CAF Q-1 and in PREM Q-1, if you select an Insurance Plan described in CAF Q-2, then you may be required to pay a portion of the contributions. When you complete the Election Form/Salary Reduction Agreement, if you elect to pay for benefits on a pre-tax basis you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

The Employer may contribute all, some, or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you from time to time.

Miscellaneous

MISC Q-1

What are my ERISA Rights?

The Cafeteria Plan is not an ERISA welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA). The SPDs of the various benefits components of the Plan will describe your rights under ERISA, if applicable, under that component.

Regardless, a participant in the Cafeteria Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;

- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights. You have a right to continue your Health Insurance Plan coverage for yourself if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

HIPAA Privacy Rights. Under another provision of HIPAA, group health plans are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer (or medical insurers) that outlines its health privacy policies.

Fiduciary Obligations. In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other participants.

No Discrimination. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Right to Review. If your claim for a benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforcing Your Rights. Under ERISA, there are steps that you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, then you may file suit in a state or federal court (but only if you have first filed your claim under the Plan's claims procedures and, if applicable, filed a timely appeal of any denial of your claim).

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration

MISC Q-2. What other general information should I know?

This MISC Q-2 contains certain general information that you may need to know about the Plan.

Plan Information

Official Name of the Plan: ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan

Plan Number: 501

Effective Date: 10/1/2025.

Plan Year: 10/1/2025 to 9/30/2026. Your Plan's records are maintained on this period of time

Type of Plan: Welfare plan providing various insurance benefits

Employer/Plan Sponsor Information

Name and Address:

ARK TEX COUNCIL OF GOVERNM FBP

PO BOX 5307
TEXARKANA, TX 75505
Federal employee tax identification number (EIN): 751293383

Plan Administrator Information

Name, Address, and business telephone number:

ARK TEX COUNCIL OF GOVERNM FBP

PO BOX 5307
TEXARKANA, TX 75505
Attention: Human Resources Manager
Telephone: 9038328636

Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

ARK TEX COUNCIL OF GOVERNM FBP

PO BOX 5307
TEXARKANA, TX 75505
Attention: Benefits Committee

Qualified Medical Child Support Order

The Health Insurance Plans will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Appendix A

*****Affiliated Employers*****

Appendix B

COBRA CONTINUATION COVERAGE RIGHTS under the ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan (the "Plan")

The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. **PLEASE READ THE FOLLOWING CAREFULLY.**

The ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan has group health insurance components and you may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan or by ARK TEX COUNCIL OF GOVERNM FBP. The Plan provides no greater COBRA rights than what COBRA requires - nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA?"

COBRA coverage may become available to "qualified beneficiaries"

After a qualifying event occurs and any required notice of that event is properly provided to ARK TEX COUNCIL OF GOVERNM FBP, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

Who Is Entitled to Elect COBRA?

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

Qualifying events for the covered employee

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

Qualifying events for the covered spouse

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Qualifying events for dependent children

If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;

- your parent-employee's employment ends for any reason other than his or her gross misconduct;
- you stop being eligible for coverage under the Plan as a "dependent child."

Electing COBRA after leave under the Family and Medical Leave Act (FMLA)

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact ARK TEX COUNCIL OF GOVERNM FBP for more information about these special rules.

Special second election period for certain eligible employees who did not elect COBRA

Certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after Plan coverage is lost).

When Is COBRA Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify ARK TEX COUNCIL OF GOVERNM FBP of any of these qualifying events.

Caution:

You stop being eligible for coverage as dependent child whenever you fail to satisfy any part of the plan's definition of dependent child.

You must notify the plan administrator of certain qualifying events by this deadline

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify ARK TEX COUNCIL OF GOVERNM FBP in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

No COBRA election will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form" and you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to ARK TEX COUNCIL OF GOVERNM FBP during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

How to elect COBRA

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and mail or hand-deliver it to ARK TEX COUNCIL OF GOVERNM FBP. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from ARK TEX COUNCIL OF GOVERNM FBP.

Deadline for COBRA election

If mailed, your election must be postmarked (or if hand-delivered, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Independent election rights

Each qualified beneficiary will have an independent right to elect COBRA.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage

under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods.

COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

Death, divorce, legal separation, or child's loss of dependent status

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage under the Plan's Medical and Dental components can last for up to a total of 36 months.

If the covered employee becomes entitled to Medicare within 18 months before his or her termination of employment or reduction of hours.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan's Medical and Dental components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Termination of employment or reduction of hours

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage under the Plan's Medical and Dental components generally can last for only up to a total of 18 months.

Extension of Maximum Coverage Period

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify ARK TEX COUNCIL OF GOVERNM FBP of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify ARK TEX COUNCIL OF GOVERNM FBP in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

You must notify ARK TEX COUNCIL OF GOVERNM FBP of a qualified beneficiary's disability by this deadline

The disability extension is available only if you notify ARK TEX COUNCIL OF GOVERNM FBP in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

No disability extension will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Disability Form" and you must follow the notice procedures specified in the section below entitled "Notice Procedures."

If these procedures are not followed or if the notice is not provided to ARK TEX COUNCIL OF GOVERNM FBP during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage.

Second qualifying event extension of COBRA coverage

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

You must notify ARK TEX COUNCIL OF GOVERNM FBP of a second qualifying event by this deadline

This extension due to a second qualifying event is available only if you notify ARK TEX COUNCIL OF GOVERNM FBP in writing of the second qualifying event within 60 days after the date of the second qualifying event.

No extension will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Second Qualifying Event Form" (you may obtain a copy of this form from ARK TEX COUNCIL OF GOVERNM FBP at no charge), and you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to ARK TEX COUNCIL OF GOVERNM FBP during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify ARK TEX COUNCIL OF GOVERNM FBP if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage

You must notify ARK TEX COUNCIL OF GOVERNM FBP in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. In addition, if you were already entitled to Medicare before electing COBRA, notify Employer of the date of your Medicare entitlement at the address shown in the section below entitled "Notice Procedures."

You must notify ARK TEX COUNCIL OF GOVERNM FBP if a qualified beneficiary ceases to be disabled

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify ARK TEX COUNCIL OF GOVERNM FBP of that fact within 30 days after the Social Security Administration's determination.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the

cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Payment for COBRA Coverage

How premium payments must be made

All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When premium payments are considered to be made

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

First payment for COBRA coverage

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.)

You are responsible for making sure that the amount of your first payment is correct. You may contact ARK TEX COUNCIL OF GOVERNM FBP using the contact information provided below to confirm the correct amount of your first payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

<u>If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.</u>

Monthly payments for COBRA coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. ARK TEX COUNCIL OF GOVERNM FBP will not send periodic notices of payments due for these coverage periods (that is, <u>we will not send a bill to you for your COBRA coverage - it is your responsibility to pay your COBRA premiums on time</u>).

Grace periods for monthly COBRA premium payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

<u>If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.</u>

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered employee during a period of COBRA coverage

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by ARK TEX COUNCIL OF GOVERNM FBP during the covered employee's period of employment with ARK TEX COUNCIL OF GOVERNM FBP is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

NOTICE PROCEDURES ARK TEX COUNCIL OF GOVERNM FBP Welfare Benefits Plan (the Plan)

WARNING: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on Plan Forms

Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this SPD, and you may obtain copies from ARK TEX COUNCIL OF GOVERNM FBP without charge). Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

How, When, and Where to Send Notices

You must mail or hand-deliver your notice to:

Human Resources Manager

ARK TEX COUNCIL OF GOVERNM FBP
PO BOX 5307
TEXARKANA TX 75505

However, if a different address for notices to the Plan appears in the Plan's most recent summary plan description, you must mail or hand-deliver your notice to that address (if you do not have a copy of the Plan's most recent summary plan description, you may request one from ARK TEX COUNCIL OF GOVERNM FBP).

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You must notify the plan administrator of certain qualifying events by this deadline," "You must notify ARK TEX COUNCIL OF GOVERNM FBP of a qualified beneficiary's disability by this deadline", and "You must notify ARK TEX COUNCIL OF GOVERNM FBP of a second qualifying event by this deadline.")

Information Required for All Notices

Any notice you provide must include (1) the name of the Plan (ARK TEX COUNCIL OF GOVERNM FBP Welfare Benefits Plan); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying ARK TEX COUNCIL OF GOVERNM FBP that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to ARK TEX COUNCIL OF GOVERNM FBP that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability

Any notice of disability that you provide must include (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has

subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event

Any notice of a second qualifying event that you provide must include (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices

The covered employee, a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

THIS CONCLUDES THE SUMMARY OF YOUR CONTINUATION COVERAGE RIGHTS UNDER COBRA. PLEASE CONTACT THE HUMAN RESOURCES OFFICE (OR THE EQUIVALENT THEREOF) OF ARK TEX COUNCIL OF GOVERNM FBP IF YOU HAVE ANY QUESTIONS OR NEED MORE INFORMATION.

ARK TEX COUNCIL OF GOVERNM FBP Cafeteria Plan Summary Plan Description Addendum with Regard to Health Savings Accounts

HSA Q-1. What are "HSA Benefits"?

As described in HSA Q-2, an HSA permits Employees to make pre-tax contributions to an HSA established and maintained outside the Plan with the Employee's HSA trustee/custodian. For purposes of this Cafeteria Plan, HSA Benefits consist solely of the ability to make such pre-tax contributions under this Cafeteria Plan.

If you elect HSA Benefits, then you will be able to provide a source of pre-tax contributions by entering into a Salary Reduction Agreement with your Employer. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA taxes.

To participate in the HSA Benefits, you must be an "HSA-Eligible Individual." This means that you are eligible to contribute to an HSA under the requirements of Code § 223 and that you have elected qualifying High Deductible Health Plan coverage offered by the Employer and have not elected any disqualifying non- High Deductible Health Plan coverage offered by the Employer. ("High Deductible Health Plan" means the high deductible health plan offered by your Employer that is intended to qualify as a high deductible health plan under Code § 223(c)(2), as described in materials that will be provided separately to you by the Employer.) If you elect HSA Benefits, you will be required to certify that you meet all of the requirements under Code § 223 to be eligible to contribute to an HSA. These requirements include such things as not having any disqualifying coverage and you should be aware that coverage under a Spouse's plan could make you ineligible to contribute to an HSA.

In order to elect HSA Benefits under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian and you must provide sufficient identifying information about your HSA to facilitate the forwarding of your pre-tax Salary Reductions through the Employer's payroll system to your designated HSA trustee/custodian.

HSA Q-2. What is my "HSA"?

The HSA is not an employer-sponsored employee benefit plan it is an individual trust or custodial account that you open with an HSA trustee/custodian to be used primarily for reimbursement of "eligible medical expenses" as set forth in Code § 223. Your HSA is administered by your HSA trustee/custodian. Consequently, an HSA trustee/custodian, not the Employer, will establish and maintain your HSA. Your Employer's role is limited to allowing you to contribute to your HSA on a pre-tax Salary-Reduction basis. The HSA trustee/custodian will be chosen by you, as the Participant, and not by the Employer. Your Employer may, however, limit the number of HSA providers to whom it will forward pretax Salary Reductions, a list of whom will be provided upon request. Any such list of HSA trustees/custodians, however, shall be maintained for administrative simplification and shall not be an endorsement of any particular HSA trustee/custodian. Your Employer has no authority or control over the funds deposited in your HSA.

The Plan Administrator will maintain records to keep track of HSA contributions that you make via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose.

HSA Q-3. What are the maximum HSA Benefits that I may elect under the Cafeteria Plan?

Your annual contribution for HSA Benefits is equal to the annual benefit amount that you elect (for example, if a $2,000 annual benefit amount is elected for 2010, then the annual contribution amount is also $2,000). The amount you elect must not exceed the statutory maximum amount for HSA contributions applicable to your High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made. (Note: The statutory limits for 2023 are $3,850 for single and $7,750 for family. The 2024 limits have been updated to $4,150 for single and $8,300 for family and the 2025 limits are $4,300 for single and $8,550 for family.) An additional catch-up contribution of up to $1,000 may be made if you are age 55 or older.

In addition, the maximum annual contribution shall be: (a) reduced by any matching (or other) Employer contribution made on your behalf with Pre-Tax salary reductions made under the Plan; and (b) pro-rated for the number of months in which you are an HSA-Eligible Individual.

Note that if you are an HSA-Eligible Individual for only part of the year but you meet all of the requirements under Code § 223 to be eligible to contribute to an HSA on December 1, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (i.e., single or family). However, any contributions in excess of your annual contribution under the Plan for HSA benefits (as described above), but not in excess of the applicable full statutory maximum amount, must be made outside the Plan. In addition, if you do not remain eligible to contribute to an HSA under the requirements of Code § 223 during the following year, the portion of HSA contributions attributable to months that you were not actually eligible to contribute to an HSA will be includible in your gross income and subject to a 10% penalty (exceptions apply in the event of death or disability).

HSA Q-4. How are my HSA Benefits paid for under the Cafeteria Plan?

When you complete the Salary Reduction Agreement, you specify the amount of HSA Benefits that you wish to pay for with your salary reduction. From then on, you make a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

For example, suppose that you have elected to contribute up to $2,000 per year for HSA Benefits and that you have chosen no other benefits under the Cafeteria Plan. If you pay all of your contributions, then our records would reflect that you have contributed a total of $2,000 during the Plan Year. If you are paid biweekly, then our records would reflect that you have paid $76.92 ($2,000 divided by 26) each pay period in contributions for the HSA Benefits that you have elected. Such contributions will be forwarded to the HSA trustee/custodian (or its designee) within a reasonable time after being withheld.

The Employer may make contributions to your HSA, however, your Employer has no authority or control over the funds deposited in your HSA.

HSA Q-5. Will I be taxed on the HSA Benefits that I receive?

You may save both federal income taxes and FICA taxes by participating in the Cafeteria Plan. However, very different rules apply with respect to taxability of HSA Benefits than for other Benefits offered under this Plan. For more information regarding the tax ramifications of participating in an HSA as well as the terms and conditions of your HSA you may want to refer to the communications materials provided by your HSA trustee/custodian as well as IRS Publication 969 ("Health Savings Accounts and Other Tax-Favored Health Plans").

The Employer cannot guarantee that specific tax consequences will flow from your participation in the Cafeteria Plan. Ultimately, it is your responsibility to determine the tax treatment of HSA Benefits. Remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

HSA Q-6. Who can contribute to an HSA under the Cafeteria Plan?

Only Employees who are HSA-Eligible Individuals can participate in the HSA Benefits. An HSA-Eligible Individual means an individual who meets the eligibility requirements of Code § 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage. The terms of the High Deductible Health Plan that has been selected by your Employer will be further described in materials that will be provided separately to you by the Employer.

HSA Q-7. Can I change my HSA Contribution under the Cafeteria Plan?

Unlike the other benefits offered under the Cafeteria Plan, you may increase, decrease, or revoke your HSA contribution election at any time during the plan year for any reason by submitting an election change form to the Plan Administrator (or to its designee). Your election change will be prospectively effective on the first day of the month following the month in which you properly submitted your election change. Your ability to make pre-tax contributions under this Plan to the HSA identified above ends on the date that you cease to meet the eligibility requirements.

HSA Q-8. Where can I get more information on my HSA and its related tax consequences?

For details regarding your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what constitutes a qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA trust or custodial agreement and other documentation associated with your HSA and provided to you by your HSA trustee/custodian. You may also want to review IRS Publication 969 ("Health Savings Accounts and Other Tax-Favored Health Plans").

RESOLUTION NO. ATUT25-01

RESOLUTION OF THE TEXARKANA URBAN TRANSIT DISTRICT BOARD OF DIRECTORS APPROVING THE ADOPTION OF THE ATUT FLEXIBLE BENEFITS PLAN (FBP) CAFETERIA PLAN FOR FY2026.

WHEREAS, ATUT wishes to adopt the form of Cafeteria Plan, as authorized under Section 125 of the Internal Revenue Code of 1986, such Plan is presented to the Board of Directors this date; and

WHEREAS, the Plan Year shall be for a period beginning October 1, 2025, and ending September 30, 2026; and

WHEREAS, ATUT, the Employer, shall submit to the Plan amounts collected from participating employees sufficient to meet their obligation under the Cafeteria Plan, in accordance with the terms of the Plan Document, and shall notify the Plan Administrator to which periods said contributions shall be applied; and

WHEREAS, ATUT, the Employer, shall notify employees immediately of the adoption of the Cafeteria Plan by making available for review to each employee the Summary Plan Description, such form presented and approved at this meeting.

NOW, THEREFORE, BE IT RESOLVED BY THE TEXARKANA URBAN TRANSIT DISTRICT:

Section 1 - That the Board of Directors approves the Texarkana Urban Transit FBP Cafeteria Plan.

Section 2 - That Exhibits A and B attached hereto are true copies of the Plan Document and Summary Plan Description for Texarkana Urban Transit FBP's Flexible Benefits Plan.

Section 3 - That this Plan shall be made available for review by all employees of Texarkana Urban Transit upon its approval.

Section 4 - That this Resolution shall be in effect immediately upon its execution.

REVIEWED AND APPROVED THIS 22ND DAY OF SEPTEMBER, 2025.

_____

Mary Beth Rudel, President
Board of Directors
Ark-Tex Urban Transit, Inc.

ATTEST:

_____

BRIEFING PAPER

ITEM 5:

Review and consider approval of the renewal of the ATUT Ethics Policy Manual.

BACKGROUND:

On January 29, 2009, the Texas Transportation Commission adopted administrative rules that require outside entities to implement internal ethics and compliance programs. In order to remain eligible to receive the funding ATUT is required to renew the manual annually. In addition, another rule adopted on March 25, 2010, requires public transportation entities to implement and enforce a compliance program meeting the minimum rules in order to be eligible for state and federal funding awarded after January 1, 2011, by the Texas Transportation Commission.

DISCUSSION:

The rules adopted by the Texas Transportation Commission established a framework for the internal ethics and compliance program of any entity that receives financial assistance from the department. The compliance program must satisfy certain requirements, with the goal of discouraging fraud and illegal activity. TXDOT also instituted an internal ethics and compliance program designed to further encourage ethical behavior within the department and compliance with the law and departmental policies.

As a result of these rules, the Ark-Tex Urban Transit (ATUT) compiled an “Ethics Policy Manual” consisting of sections covering all requirements, including Record Retention, Fraud, Equal Opportunity Employment, Sexual Harassment and Sexual Misconduct, Conflicts of Interest, Personal Use of Property, and Gifts and Honoraria. The manual also includes a copy of the Code of Ethics, which mirrors what was established by the American Society for Public Administration and incorporates the general principles of ethical conduct set forth in Executive Order 12674. This Ethics Policy Manual was approved by the Board of Directors in September of 2014, making our agency eligible to apply for and receive state and federal funding.

ATUT enforces a compliance program by reviewing and providing all employees a copy of the “Ethics Policy Manual” during new hire orientation; by conducting yearly Ethics Manual Training that is mandatory for all employees; by reminding Board members of the standard of ethical behavior that our employees and board members must meet; by internal controls used to monitor activities; and by conducting investigations of any alleged misconduct.

RECOMMENDATION:

Staff recommends approval.

ARK-TEX URBAN TRANSIT, INC.

Employee Ethics Policies

SEPTEMBER 2014

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SECTION I

RECORDS RETENTION

I. RECORDS RETENTION

A. GENERAL POLICY

Ark-Tex Urban Transit, Inc. (ATUT) is committed to proper maintenance and retention of records. Records are defined broadly to include almost any type of business information, and the required retention period varies with the type of record. Falsifying records, deliberately concealing records, destroying records in bad faith, exploiting confidential information, or otherwise mishandling records is not acceptable.

B. LOCAL GOVERNMENT CODE

As a subsidiary of a local government, ATUT must adhere to Local Government Code, Chapters 202 – 204, addressing records management. Records management includes the application of management techniques to the creation, use, maintenance, retention, preservation, and disposal of records for the purposes of reducing the costs and improving the efficiency of recordkeeping [Local Government Code § 201.003(8)].

C. WRONGFUL DESTRUCTION OF RECORDS

When a lawsuit is filed or is reasonably anticipated to be filed against this agency, or when an internal or governmental investigation is initiated, ATUT must ensure that all information potentially relevant to the suit or investigation is preserved. Employees may not alter, conceal, or in any way destroy information potentially relevant to a suit or investigation.

ATUT will take every step possible to ensure potentially relevant information is not inadvertently destroyed pursuant to document retention schedules or by routine computer operations or common computer settings, such as the automated deletion of e-mails.

D. TERMINATION

Any employee who violates this policy and destroys information, either through willful or unintentional act, will be subject to disciplinary action, up to and including termination. Engaging in unlawful destruction of records may also result in civil or criminal liability to any employee of ATUT committing such acts.

E. ADMINISTRATION

The Manager and the Administration Supervisor are responsible for the administration and application of this Policy. Any improper destruction of records will be considered fraud and will be investigated as such in conjunction with the Human Resources Office and the Executive Director. (See II. Fraud).

SECTION II

FRAUD

II. FRAUD

A. GENERAL POLICY

Fraud is broadly defined and may include any type of intentional deception for the purpose of personal or business gain or damage to an individual or organization. Engaging in acts of fraud may result in civil or criminal liability to any employee of Ark-Tex Urban Transit, Inc. (ATUT) committing such acts.

This Fraud Policy is established to facilitate the development of controls that will aid in the detection and prevention of fraud against ATUT. It is the intent of ATUT to promote consistent organizational behavior by providing guidelines and assigning responsibility for the development of controls and conduct of investigations.

B. SCOPE OF WORK

This Fraud Policy applies to any irregularity, or suspected irregularity, involving employees, consultants, vendors, contractors, outside agencies doing business with employees of such agencies, and/or any other parties with a business relationship with ATUT.

Any investigative activity required will be conducted without regard to the suspected wrongdoer's length of service, position/title, or relationship to ATUT.

C. POLICY RESPONSIBILITY

Management is responsible for the detection and prevention of fraud, misappropriations, and other irregularities. Fraud includes the intentional, false representation or concealment of a material fact for the purpose of inducing another to act upon it to his or her benefit. Examples of fraud include lying on an employment application, falsifying records, or providing false receipts for reimbursement from ATUT.

Each member of management should be familiar with the types of improprieties that might occur within his or her area of responsibility and should be alert for any indication of irregularity. Any irregularity that is detected or suspected must be reported immediately to the Administration Supervisor, the Manager or the Human Resources Office, who coordinates all investigations with the appropriate authorities, both internal and external.

D. ACTIONS CONSTITUTING FRAUD

The terms defalcation, misappropriation, and other fiscal irregularities refer to, but are not limited to:

- Any dishonest or fraudulent act;
- Misappropriation of funds, securities, supplies, or other assets;
- Impropriety in the handling or reporting of money or financial transactions;

- Accepting or seeking anything of material value from contractors, vendors, or persons providing services/materials to ATUT (Exception: Gifts less than $50 in value that can be used/enjoyed by all employees, i.e., cookies at Christmas);
- Destruction, removal, or inappropriate use of records, furniture, fixtures, buses and equipment; and/or
- Any similar or related irregularity.

E. OTHER IRREGULARITIES

Irregularities concerning an employee's moral, ethical, or behavioral conduct should be resolved by supervisor and the Manager.

If there is any question as to whether an action constitutes fraud, contact the Manager immediately for guidance.

F. INVESTIGATION RESPONSIBILITIES

Employees must be good stewards of resources entrusted to them and exercise due diligence to prevent and detect criminal conduct and noncompliance with laws and policies. All employees must report suspected fraud, waste, abuse or noncompliance to the Administration Supervisor, the Manager or the Human Resources Office immediately.

The Manager has the primary responsibility for the investigation of all suspected fraudulent acts as defined in this Fraud Policy. If the investigation substantiates that fraudulent activities have occurred, the Manager will issue reports to appropriate designated personnel and to the Board of Directors through the Audit Committee.

Decisions to prosecute or refer the examination results to the appropriate law enforcement and/or regulatory agencies for independent investigation will be made in conjunction with legal counsel, the Manager and the Executive Director, as will final decisions on disposition of the case.

G. CONFIDENTIALITY

The Manager, the Administration Supervisor and the Human Resources Office will treat all information received in a confidential manner. Any employee who suspects dishonest or fraudulent activity will notify either the Manager, the Administration Supervisor or the Human Resources Office immediately, and should not attempt to personally conduct investigations or interviews/interrogations related to any suspected fraudulent act. (See **Reporting Procedure** below)

Investigation results will not be disclosed or discussed with anyone other than those who have a legitimate need to know. This is important in order to avoid damaging the reputations of persons suspected, but subsequently found innocent, of wrongful conduct and to protect ATUT from potential civil liability.

H. AUTHORIZATION FOR INVESTIGATING SUSPECTED FRAUD

The Manager, the Administration Supervisor and the Human Resources Office will have:

- Free and unrestricted access to all company records and premises, whether owned or rented; and
- The authority to examine, copy, and/or remove all or any portion of the contents of files, desks, cabinets, and other storage facilities on the premises without prior knowledge or consent of any individual who might use or have custody of any such items or facilities when it is within the scope of their investigation.

I. REPORTING PROCEDURES

Great care must be taken in the investigation of suspected improprieties or irregularities so as to avoid mistaken accusations or alerting suspected individuals that an investigation is underway.

An employee who discovers or suspects fraudulent activity will contact the Manager, the Administration Supervisor or the Human Resources Office immediately, or may contact the toll-free Fraud Hot line at 800/892-8548. The employee or other complainant may remain anonymous. All inquiries concerning the activity under investigation from the suspected individual, his or her attorney or representative, or any other inquirer should be directed to the Manager. No information concerning the status of an investigation will be given out. (Additional reporting tips found at https://www.txdot.gov/inside-txdot/division/compliance/reporting-fraud.html)

The reporting individual should be informed of the following:

- Do not contact the suspected individual in an effort to determine facts or demand restitution.
- Do not discuss the case, facts, suspicions, or allegations with anyone unless specifically asked to do so by the Manager.

J. TERMINATION

If an investigation results in a recommendation to terminate an individual, the recommendation will be reviewed for approval by the Executive Director and, if necessary, outside counsel before any action is taken.

K. ADMNISTRATION

The Manager and the Administration Supervisor are responsible for the administration, revision, interpretation, and application of this Policy. As part of the Ethics Manual, the Fraud Policy will be reviewed annually and revised as needed.

SECTION III

EQUAL OPPORTUNITY EMPLOYMENT

III. EQUAL OPPORTUNITY EMPLOYMENT

A. GENERAL POLICY

Ark-Tex Urban Transit, Inc. (ATUT) is an equal opportunity employer. It is the policy of ATUT to promote and ensure equal employment opportunities to all applicants for employment and to all employees regardless of race, color, religion, age, sex, national origin, disability status, genetics, protected veteran status, sexual orientation, or gender identity or expression.

This Equal Opportunity Employment Policy is adopted to prohibit discrimination against any person in job structuring, recruitment, examination, selection, appointment, placement, training, promotion, demotions, discipline, or any other aspect of personnel administration based on race, color, religion, age, sex, national origin, disability status, genetics, protected veteran status, sexual orientation, or gender identity or expression. Employment, promotion, demotion, training, discipline and any relation decisions will be made only on the basis of bona fide occupational qualifications and job-related factors such as education, training, experience, knowledge, attitude, aptitude, and necessary skills and abilities to perform a specific job. Discrimination has no place at ATUT and will not be tolerated.

B. AFFIRMATIVE ACTION

The ATUT is committed to maintaining and promoting equal opportunities for all qualified employees, applicants for employment, and program services for clients without regard to their race, color, religion, age, sex, national origin, disability status, genetics, protected veteran status, sexual orientation, gender identity or expression, or any other protected characteristic. ATUT's commitment, in this regard, creates a positive obligation on the part of all management and participants for the adoption of and compliance with this affirmative action policy. Affirmative action includes, but is not limited to, hiring, placement, employment upgrading, promotions or transfers, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, selection for training, and services provided to clients. In addition, ATUT will actively seek qualified members of minority groups and other protected classes in its services to clients and application and hiring processes.

C. COMPLIANCE AND ADMINISTRATION

It is the responsibility of each and every employee to insure compliance with the Equal Employment Opportunity; however, the Manager shall have the ultimate responsibility to insure compliance with all phases of this policy.

1. The Human Resources Specialist is the Equal Employment Opportunity (EEO) Officer and, as such, is responsible to administer the ATUT's Equal Employment Opportunity Policy.

2. The EEO Officer will be responsible for:

    a. Developing and implementing an Affirmative Action Plan.

b. Assuring compliance by all employees and reporting any deviation to the Manager.

c. Maintaining records and preparing status reports as necessary.

d. Receiving, investigating, and responding to complaints in accordance with established procedures.

e. Insuring that this policy is disseminated to all employees.

D. PERSONS WITH DISABILITIES

1. It is the policy of ATUT to fully comply with the Americans With Disabilities Act of 1990 (ADA) and the ADA Amendment Act of 2008 (ADAAA), to prohibit discrimination against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.

2. In compliance with the Americans with the ADA and the ADAAA, ATUT will insure all programs and services administered by ATUT are accessible to qualified persons with disabilities. ATUT will further provide appropriate auxiliary aids and services where necessary to afford an individual with a disability an equal opportunity to participate in and to enjoy the benefits of its programs and services.

E. WHISTLEBLOWERS PROTECTION

ATUT encourages its employees to report improper activities in the workplace and will protect employees from retaliation for making any such report in good faith.

1. EMPLOYEE RIGHTS: Employees have the right to report, without suffering retaliation, any activity by ATUT or an employee of ATUT that the reporting employee reasonably believes:

   a. Violates any state or federal law;

   b. Violates or amounts to noncompliance with a state or federal rule or regulation; or

   c. Violates fiduciary responsibilities to its employees.

   In addition, employees can refuse to participate in an activity that would result in a violation of state or federal statutes, or a violation or noncompliance with a state or federal rule or regulation.

   Employees are also protected from retaliation for having exercised any of these rights in any former employment.

The whistleblower protection laws do not entitle employees to violate a confidential privilege of ATUT (such as the attorney-client privilege) or improperly disclose trade-secret information.

2. WHERE TO REPORT: Employees have the duty to comply with all applicable laws and to assist ATUT to ensure legal compliance. An employee who suspects a problem with legal compliance is required to report the situation(s) to their supervisor or other appropriate member of management, to include the Executive Director.

3. PROTECTION FROM RETALIATION: Any employee who believes they have been retaliated against for whistleblowing may file a complaint with ATUT's Equal Employment Opportunity (EEO) Officer. The EEO Officer, designated by the Executive Director, shall be responsible for receipt, documentation, investigation and report of all such complaints in accordance with established procedures.

F. ADMINISTRATION

The Human Resources Coordinator as the Equal Employment Opportunity (EEO) Officer shall be responsible for receipt, documentation, investigation, and report of all such complaints of violations of the Equal Opportunity Employment Policy in accordance with established procedures.

SECTION IV

SEXUAL HARRASSMENT,

SEXUAL MISCONDUCT, AND BULLYING

IV. SEXUAL HARRASSMENT, SEXUAL MISCONDUCT, AND BULLYING

A. GENERAL POLICY

It is the policy of Ark-Tex Urban Transit, Inc. (ATUT) to provide an employment environment free of sexual harassment or sexual misconduct. Any and all forms of sexual harassment and/or sexual misconduct are strictly prohibited and ATUT will not tolerate any such form(s) of harassment or misconduct in the workplace.

B. SEXUAL HARASSMENT

Sexual harassment may include sexual advances, sexual solicitation, requests for sexual favors, or other verbal or physical conduct of a sexual nature where any of the three criteria exist:

1. Submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's employment or continued employment;

2. Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual; or,

3. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive work environment.

C. SEXUAL MISCONDUCT

Sexual misconduct includes behavior that is short of sexual harassment, but may include offensive language, offensive jokes, offensive bantering or any other behavior of a sexual nature deemed to be offensive and unwelcomed by the employee who is offended. This sexual misconduct is unprofessional and inappropriate and it will not be tolerated at ATUT.

D. BULLYING

Any and all forms of bullying are strictly prohibited. Bullying is defined as any form of intimidation or aggressive behavior in which someone intentionally and repeatedly causes another person injury or discomfort. Bullying can take the form of physical contact, words or more subtle actions or attacks.

E. CONDUCT EXPECTATIONS

It is the expectation of ATUT that all employees will treat each other and the general public with professionalism, respect and fairness. Employees must conduct themselves with courtesy and restraint at all times on the job and at all times when they may be perceived in any manner as representing ATUT.

F. REPORTING PROCEDURES

1. Any employee who feels he/she is being subjected to sexual harassment or sexual misconduct by any person in the workplace must report the incident to the appropriate supervisor or the Manager immediately. Likewise, any employee who witnesses any incident that appears to be a violation of sexual harassment or sexual misconduct policies is also required to report the incident immediately. If the subject of a complaint is the employee's supervisor or the Manager, the employee must report the complaint directly to the Human Resources Office or the Executive Director.

2. Supervisors who receive reports of sexual harassment or sexual misconduct must report the complaint(s) to the Human Resources Office, the Administration Supervisor or to the Manager, regardless of the form of the complaint (formal or informal) or whether it precisely follows ATUT's complaint procedures. Ignoring a report of sexual harassment or sexual misconduct is unacceptable.

3. Accurate records of all complaints must be kept. Supervisors will work with the Human Resources Office, the Administration Supervisor and the Manager to ensure appropriate action that actually stops the harassment or misconduct is taken.

G. PROTECTION FROM RETALIATION

ATUT encourages its employees to report any sexual harassment or sexual misconduct in the workplace. Employees who report any form of sexual harassment or sexual misconduct are protected against retaliation by state and federal laws. (See III. Equal Opportunity Employment, E. Whistleblowers Protection)

H. TERMINATION

Sexual harassment and/or sexual misconduct will not be tolerated. Disciplinary action will be taken against any employee who is proven through investigation to have engaged in such activity, up to and including termination.

I. ADMINISTRATION

The Human Resources Office, the Administration Supervisor and the Manager are responsible for the receipt, documentation, investigation and report of all such complaints of sexual harassment or sexual misconduct.

SECTION V

CONFLICTS OF INTEREST

V. CONFLICTS OF INTEREST

A. GENERAL POLICY

Conflict of interest is a situation in which the private interest of an employee or officer of Ark-Tex Urban Transit, Inc. (ATUT) conflicts with or raises a reasonable question of conflict with job-related duties or responsibilities of that employee or officer. This is usually financial or economic in nature.

B. EMPLOYEES

An employee shall not engage in any activity that would create a conflict of interest or even the appearance of a conflict, to include:

1. Make a personal investment in any enterprise that would create a substantial conflict between the employee's private interest and ATUT.

2. Engage in outside business or professional activities or accept employment if the activities create a conflict between the employee's private interests and ATUT.

3. Use or appear to use information obtained in connection with the employee's duties for ATUT or that could be expected to impair the employee's independence of judgment in the performance of the employee's duties for ATUT.

C. PUBLIC OFFICIALS

Local public officials, including a member of the ATUT governing body or another officer, whether elected, appointed, paid or unpaid, are subject to the Conflict of Interest provisions in Chapter 171 of the Texas Local Government Code. Chapter 171 establishes the standard for determining when a local official has a conflict of interest that would affect his or her ability to discuss, decide or vote on a particular item.

1. Officers of ATUT will neither have financial interests in the profits of any contract, service, or other work performed for ATUT nor derive personal profit directly or indirectly from any contract, purchase, sale, or service between the ATUT and any person or company.

2. An officer shall not:

    a. Participate in the selection, award, or administration of a contract in which public funds are used where, to their knowledge, they or their immediate families or partners or organizations in which their immediate families or partners have a financial interest or with whom they are negotiating or have any arrangement concerning prospective employment.

b. Solicit or accept gratuities, favors or anything of monetary value from potential or existing contractors or vendors.

c. Solicit or accept or agree to accept a financial benefit, other than from ATUT, that might reasonably tend to influence his or her performance of duties for ATUT or that he knows or should know is offered with intent to influence the officer's performance;

d. Accept employment or compensation that might reasonably induce him to disclose confidential information acquired in the performance of official ATUT duties or that might reasonably tend to impair independence of judgment in performance of official ATUT duties;

e. Make any personal investment that might reasonably be expected to create a substantial conflict between the officer's private interest and responsibilities for ATUT; or

f. Solicit or accept or agree to accept a financial benefit from another person in exchange for having performed duties as an ATUT officer in favor of that person.

D. CONTRACTS

1. With reference to contracts, no officer or employee of ATUT who exercises any functions or responsibilities in the review or approval of an undertaking or the carrying out of one of the ATUT's contracts shall participate in any decision relating to that contract if the decision affects his personal pecuniary interest.

2. Officers and other members of the ATUT governing body must file a conflicts disclosure statement relating to any person that ATUT has contracted with or is considering contracting with if that officer or member of the governing body or any of their family members has certain business relationships with that person.

E. ADMINISTRATION

The Manager and the Administration Supervisor are responsible for the administration, interpretation, and application of this Conflicts of Interest Policy. Legal counsel will be consulted as necessary in coordination with the Executive Director in order to ensure all provisions of this Policy are strictly adhered to.

SECTION VI

PERSONAL USE OF

ATUT PROPERTY

VI. PERSONAL USE OF ATUT PROPERTY

A. GENERAL POLICY

It is the policy of Ark-Tex Urban Transit, Inc. (ATUT) to provide each employee with all reasonable and n ecessary tools, equipment, and property to adequately perform their job. All such tools, equipment and property owned by, leased by or provided to ATUT may only be used for official purposes.

B. USE OF TOOLS, EQUIPMENT AND PROPERTY

1. Employees who are assigned tools, buses, equipment, or any other ATUT property are responsible for them and for their proper use and maintenance.

2. ATUT tools, buses, equipment, materials, supplies, or property may not be used for personal or political use.

C. USE OF INFORMATION SYSTEMS RESOURCES

1. Employees who are assigned information system resources, including personal computers and peripheral devices, are responsible for them and for their proper use and maintenance.

2. ATUT information system resources may not be used for personal or political use.

D. USE OF BUILDINGS AND PREMISES

Use of ATUT buildings and premises by employees shall be in compliance with law and with ATUT policies regarding authorized uses and may not be used for personal or political use.

F. MISUSE OF ATUT PROPERTY

Any misuse or unauthorized use of ATUT's property, including information system resources, is subject to disciplinary action. Misuse of official property may also result in criminal prosecution.

SECTION VII
GIFTS AND HONORARIA

VII. GIFTS AND HONORARIA

A. GENERAL POLICY

Employees and officers of Ark-Tex Urban Transit, Inc. (ATUT) are prohibited from accepting any favor or gift from a person who wants, or may want, or may be seen to want, an official favor within the authority of that employee or officer.

B. GIFTS TO EMPLOYEES

It is unethical for any ATUT employee to accept or give a gift that is meant to sway a decision in favor of the gift-giver. Employees may not:

1. Solicit or accept, directly or indirectly, any gift, gratuity, favor, entertainment, or any other thing of monetary value, from a person who has, or is seeking to obtain, contractual or other business or financial relations with ATUT.

2. Solicit a contribution from another employee for a gift to an official superior, make a donation as a gift to an official superior, or accept a gift from an employee receiving less pay than the employee. However, this paragraph does not prohibit a voluntary gift of nominal value or donation in a nominal amount made on a special occasion such as marriage, illness, or retirement.

3. Any such gift or gratuity, the receipt of which is prohibited by this policy, shall be returned to the donor with a written explanation as to why the return is necessary.

C. GIFTS TO OFFICERS

Officers or other members of the governing body are prohibited from accepting any gift that would sway a decision in favor of the gift-giver.

1. Officers and members of the governing body must disclose a vendor's offer of gifts worth a value of $250 or more to them or to any family member using the Conflict of Interest Form approved by the Texas Ethics Commission.

2. Local Government Code Chapter 176 requires that the officer or member of the governing body disclose this offer of a gift even if the offer is refused.

3. An officer or member of the governing body who knowingly violates the disclosure requirements and violates Local Government Code Chapter 176 commits a Class C misdemeanor.

D. GIFTS TO STATE EMPLOYEES

State employees are legally and ethically prohibited from accepting gifts and honoraria, except in very limited situations.

1. ATUT employees are prohibited from offering or conferring any benefit to a
State employee in exchange for the recipient's decision, opinion, recommendation, vote or other exercise of discretion as a public servant that would benefit either ATUT or the employee.

2. "Benefit" is defined as anything reasonably regarded as financial gain or financial advantage, including a benefit to any other person in whose welfare the beneficiary has an interest. Benefit does not include an item with a value of less than $50 or a small gift or other benefit conferred on account of kinship or an independent relationship.

3. ATUT employees may be held criminally liable for violation of this Policy.

E. ADMINISTRATION

The Manager and Administration Supervisor are responsible for administration and interpretation of this Policy and will investigate any report of wrongdoing.

THIS ETHICS MANUAL IS APPROVED FOR ADOPTION THIS 24TH DAY OF SEPTEMBER, 2024.

Mary Beth Rudel

Mary Beth Rudel, President
Ark-Tex Urban Transit, Inc.

ATTEST:

Leslie McBride

Leslie McBride, Vice-President
Ark-Tex Urban Transit, Inc.

VIII. CODE OF ETHICS

Public service is a public trust, requiring employees to place loyalty to the Constitution, the laws, and ethical principles above private gain.

I. Serve the Public Interest

Serve the public, beyond serving oneself.

ATUT employees shall:

a. Exercise discretionary authority to promote the public interest.
b. Adhere to all laws and regulations that provide equal opportunity for all Americans, regardless of race, color, religion, age, sex, national origin, disability status, genetics, protected veteran status, sexual orientation, or gender identity or expression.
c. Recognize and support the public's right to know the public's business.
d. Not engage in financial transactions using non-public government information or allow the improper use of such information to further any private interest.
e. Not, except as permitted by regulation, solicit or accept any gift or other item of monetary value from any person or entity seeking official action from, doing business with, or conducting activities regulated by the employee's agency, or persons whose interests may be substantially affected by the performance or non-performance of the employee's duties.
f. Not knowingly make unauthorized commitments or promises of any kind purporting to bind the government.
g. Not use public office for private gain.
h. Protect and conserve public property and shall not use it for other than authorized activities.
i. Exercise compassion, benevolence, fairness and optimism.
j. Respond to the public in ways that are complete, clear, and easy to understand.
k. Assist citizens in their dealings with government.
l. Be prepared to make decisions that may not be popular.

II. Respect the Constitution and the Law

Respect, support, and study government constitutions and laws that define responsibilities of public agencies, employees, and all citizens.

ATUT employees shall:

a. Understand and apply legislation and regulations relevant to their professional role.
b. Work to improve and change laws and policies that are counter-productive or obsolete.
c. Eliminate unlawful discrimination.
d. Prevent all forms of mismanagement of public funds by establishing and maintaining strong fiscal and management controls, and by supporting audits and investigative activities.
e. Respect and protect privileged information.
f. Encourage and facilitate legitimate dissent activities in government and protect the whistle-blowing rights of public employees.
g. Promote constitutional principles of equality, fairness, representativeness, responsiveness and due process in protecting citizens' rights.

III. Demonstrate Personal Integrity

Demonstrate the highest standards in all activities to inspire public confidence and trust in public service.

ATUT employees shall:

a. Maintain truthfulness and honesty and not compromise them for advancement, honor, or financial gain.
b. Ensure that others receive credit for their work and contributions.
c. Zealously guard against conflict of interest or its appearance: e.g., nepotism, improper outside employment, misuse of public resources or the acceptance of gifts.
d. Respect superiors, subordinates, colleagues, and the public.
e. Take responsibility for his/her own errors.
f. Conduct official acts without partisanship.
g. Act impartially and shall not give preferential treatment to any private organization or individual.
h. Put forth honest effort in the performance of their duties.
i. Endeavor to avoid any actions creating the appearance that they are violating the law or the ethical standards set forth in this part.

IV. Promote Ethical Organizations

Strengthen organizational capabilities to apply ethics, efficiency and effectiveness in serving the public.

ATUT employees shall:

a. Enhance organizational capacity for open communication, creativity, and dedication.
b. Subordinate institutional loyalties to the public good.
c. Establish procedures that promote ethical behavior and hold individuals and organizations accountable for their conduct.
d. Provide organization members with an administrative means for dissent, assurance of due process and safeguards against reprisal.
e. Promote merit principles that protect against arbitrary and capricious actions.
f. Promote organizational accountability through appropriate controls and procedures.
g. Encourage organization to adopt, distribute, and periodically review a code of ethics as a living document.

V. Strive for Professional Excellence

Strengthen individual capabilities and encourage the professional development of others.

ATUT employees shall:

a. Provide support and encouragement to upgrade competence.
b. Accept as a personal duty the responsibility to keep up to date on emerging issues and potential problems.
c. Encourage others, throughout their careers, to participate in professional activities and associations.
d. Allocate time to meet with students and provide a bridge between classroom studies and the realities of public service.

This Code of Ethics primarily mirrors the Code of Ethics published by the American Society for Public Administration and incorporates the fourteen general principles of ethical conduct set forth in Executive Order 12674.

BRIEFING PAPER

ITEM 6:

Review and consider approval of revisions to the Ark-Tex Urban Transit (ATUT) Policies and Procedures Manual.

BACKGROUND

The Board of Directors is required to approve all revisions to the Policies and Procedures Manual.

DISCUSSION

The following revision to the **policy and procedures manual** are being proposed:

3.02 Holidays – The revision adds four (4) holidays to the ATUT holiday schedule and removes information that does not align with current practices.

If approved by the Board, the policy revisions will be added to the Policies and Procedures Manual.

RECOMMENDATION

Staff recommends approval.

3.02 Holidays

A holiday is a day of exemption from work granted to full-time employees as if they had actually worked. The following are recognized as paid holidays:

a. New Year's Day
b. Martin Luther King Jr. Day
c. Memorial Day
d. Juneteenth
e. Independence Day
f. Labor Day
g. Thanksgiving
h. Friday After Thanksgiving
i. Christmas Eve
j. Christmas Day

Holidays shall be paid for full-time employees who would have been regularly scheduled to work that day for the number of hours they would have regularly been scheduled to work. ~~Holidays that fall on Saturday will be observed the preceding day and holidays that fall on Sunday will be observed the next following day.~~ Holiday pay will not be considered in overtime calculations.

When any holiday falls within the period of an employee's paid vacation, holiday pay shall be added to the vacation period as time worked. Vacation leave will not be charged for the holiday.

An employee who is absent from scheduled work on the workday immediately preceding or following the holiday shall not receive holiday pay. The exceptions shall be as follows:

a. The employee is on vacation;
b. The employee has made prior arrangements, in writing, to be absent from work for medical reasons; or
c. The employee is absent due to an illness confirmed with a doctor's note.

RESOLUTION ATUT25-02

RESOLUTION OF THE ARK-TEX URBAN TRANSIT, INC. (ATUT) APPROVING REVISIONS TO THE ATUT POLICY AND PROCEDURES MANUAL.

WHEREAS, the manual was developed to ensure that the ATUT functions as a vital, evolving organization; and

WHEREAS, generally, the manual serves as the employee's primary instrument of policy guidance concerning questions of administrative and personnel policies; and

WHEREAS, upon approval, any such changes to the manual will supersede all previous policies of the same nature and will become a part of this manual.

NOW, THEREFORE, BE IT RESOLVED BY THE ARK-TEX COUNCIL OF GOVERNMENTS:

Section 1 - That the Board of Directors approves the attached revisions to the ATUT Policy and Procedures Manual.

Section 2 - That the Executive Director has full authority to act on behalf of the ATUT Board in all matters pertaining to the ATUT Policy and Procedures Manual.

Section 3 - That this resolution is approved by majority vote in accordance with the Bylaws of Ark-Tex Urban Transit and applicable law, and shall be in effect immediately upon its adoption.

REVIEWED AND APPROVED THIS 22ND DAY OF SEPTEMBER, 2025.

_____

Mary Beth Rudel, President
Board of Directors
Ark-Tex Urban Transit, Inc.

ATTEST:

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TEXARKANA URBAN TRANSIT DISTRICT
Federal FY2026 - TUTD FY 26 - 10.01.25 - 09.30.26

EXPENSES

ATUT Personnel Expenses		**FY26 DRAFT Budget**
ATUT Salaries	$	1,201,989
Overtime	$	60,000
Payroll taxes (FICA,SUTA)/Banking	$	93,806
Workers Comp	$	76,001
Health/Dental/Life	$	372,033
Retirement	$	35,008
Incentive Pay	$	12,500
Total ATUT Personnel Expenses	**$**	**1,851,337**
Operating Expenses		
Oper/Planning/Financial Support	$	54,000
Contract-Drug Test/Physicals	$	2,500
ATCOG Management Fee	$	203,648
Audit Fees	$	20,000
Copier Rental/Printing	$	5,000
Advertising/Legal	$	2,000
Computer Software & Mtn	$	4,000
Office Supplies	$	5,572
Other Direct/MISC/LOCAL	$	4,000
Postage/shipping	$	500
Travel/Training	$	1,500
Fuel	$	160,000
Oil & Lube	$	10,000
Tires/Tire Maintenance	$	20,815
Fleet Maintenance	$	75,000
Shop Supplies	$	8,000
Insurance-Property, Auto Liability	$	105,000
Telephone	$	10,000
Communications	$	14,000
Utilities	$	27,000
Building/Grounds Mtn	$	20,000
	$	752,535
TOTAL EXPENSES	**$**	**2,603,872**

REVENUE

Farebox	$	145,000
Advertising	$	71,394
Federal Award	$	1,444,017
TXDOT Award FY25	$	388,961
ArHTD	$	63,000
Local Funds	$	417,656
Unrestricted Funds Use		
In-Kind	$	73,844
TOTAL REVENUE	**$**	**2,603,872**

Texarkana, TX 59.14%	$	247,002
Texarkana, AR 35.39%	$	147,808
Wake Village, TX 2.68%	$	11,193
Nash TX 2.79%	$	11,653
Total	$	417,656